F. Total Casualty Losses.--Where an asset is entirely destroyed by fire or other casualty to the point of being unrepairable, the loss is generally considered an unallowable cost for Medicare reimbursement purposes, except where the loss related to the deductible factor of the insurance policy or the loss was such that the risk would not ordinarily be insured in adequate insurance programs. The provision of §133.1, rather than §132, applies when depreciable assets are totally lost as a result of fire or other casualty.

G. Partial Casualty Losses.--Where an asset is partially destroyed or damaged as a result of fire or other casualty, the loss, as in the case of the total casualty loss, is generally considered an unallowable cost for Medicare reimbursement purposes, except where the loss relates to the deductible factor of the insurance policy or the loss is such that it is not ordinarily insured against an adequate insurance program. See §133.3 for the procedure to follow in adjusting the cost basis of the depreciable asset to reflect the amount of the casualty losses, even though the loss is not an allowable cost for purposes of Medicare reimbursement.

2161. INSURANCE COSTS

A. Purchased Commercial Insurance.--The reasonable costs of insurance purchased from a commercial carrier or a nonprofit service corporation and not from a limited purpose insurer (see §2162.2) are allowable if the type, extent, and cost of coverage are consistent with sound management practice. Insurance premiums reimbursement is limited to the amount of aggregate coverage offered in the insurance policy.

(See §§2122.5 and 2162 regarding unemployment compensation insurance payments.) Generally, in meeting these criteria, the following types of insurance are recognized;

1. Property Damage and Destruction.--This type of insurance covers losses due to the damage to, or the destruction of, the provider's physical property. Coverage is available to insure against losses resulting from fire or lightning, windstorm, earthquake, sprinkler leakage, water damage, automobile damage, etc.

2. Liability.--This insurance includes professional liability (malpractice, error in rendering treatment, etc.), unemployment compensation, worker's compensation, automobile liability, etc. See §2162 for alternatives to insurance for malpractice and comprehensive general liability losses, as well as losses from unemployment and worker's compensation insurance coupled with second injury coverage.

3. Consequential Loss or Indirect Loss.--There are various indirect losses a provider may incur in connection with property damage or other occurrences which interrupt the normal operation of the institution. The cost of business interruption or other similar insurance is allowable; however, the premium cost for "guaranteeing profits" is not allowable.

4. Theft Insurance.--This generally includes fidelity bonds and burglary insurance. (See §2160.3.)

Where a provider has purchased insurance without the customary deductible feature and, as a result, is charged a substantially higher premium, the amount of the insurance premium which exceeds the insurance premium with the customary deductible clause is not an allowable cost.

5. Employee Health Care.--This type of insurance covers health care expenses of a provider's employees. Premiums paid by the provider to purchase this coverage usually represent a fringe benefit to the covered employees as specified in §2144.4.G.

If the health care services are rendered by a provider to its own employee and the provider is remunerated for these services under the provisions of the purchased insurance plan, the provider should not offset the reimbursement received from the insurance company against either the cost of the services rendered to the employee or the premium cost incurred to purchase the insurance coverage. Instead, the cost of services rendered by a provider to its own employee in this situation will be excluded from Medicare reimbursement by requiring the provider to include the charges and or days related to the services rendered to its employee among total charges and/or days used to apportion costs.

B. Self-Insurance.--Where a provider maintains a self-insurance program for other than malpractice and comprehensive general liability coverage in conjunction with malpractice coverage, as well as unemployment compensation and workers' compensation insurance coupled with second injury coverage, or employee health-insurance coverage, provided it meets the requirements of §2162.7, contributions to a self-insurance reserve fund referred to below are not includable in allowable costs. (See §1218.9 for the effect on equity capital.) Although contributions to the self-insurance reserve fund are not allowable, a reserve fund established under the conditions of this section need not be considered available for patient care in determining the necessity of borrowing under §202.2. However, where such a program meets the following conditions, any allowable loss cannot exceed the amount of the fund as of the date of the loss; that is, the date a claim is actually paid.

1. The provider must maintain a self-insurance reserve fund to meet any actual losses that are sustained. In the event of a loss, the amount allowable will be limited to the balance in the reserve fund at the date of the loss.

2. The provider must furnish to the intermediary pertinent details about the specific assets that are to be covered by the self-insurance reserve fund.

3. The reserve must be maintained in a segregated account and the funds must not be commingled with any other funds.

4. The self-insurance reserve must be sufficient to meet losses of the type and to the extent that they would ordinarily be covered by insurance.

5. Contributions to the reserve must be made not less frequently than annually.

6. The provider's total allowable interest expense under the Medicare program will be offset by income earned by invested insurance reserve funds.

7. Where appropriate, the provider must demonstrate the ability to effectively replace the inspection service, the loss-handling service, and the legal defense service of the insurance companies.

8. The treatment of casualty losses sustained by the self-insurance fund shall follow the procedure provided in §§1331.

2162. PROVIDER COSTS FOR MALPRACTICE AND COMPREHENSIVE GENERAL LIABILITY PROTECTION, UNEMPLOYMENT COMPENSATION, WORKERS' COMPENSATION, AND EMPLOYEE HEALTH CARE INSURANCE

A. General.--Where provider costs incurred for protection against malpractice and comprehensive general liability, or for protection against malpractice liability only, unemployment compensation, workers' compensation coupled with second injury coverage, and employee health care insurance, do not meet the requirements of §2161.A, costs incurred for that protection under other arrangements will be allowable under the conditions stated below. Costs incurred for comprehensive general liability coverage not in conjunction with malpractice liability coverage are allowable only under the provisions of §§2160 or 2161.

Usually coupled with workers' compensation laws are second injury laws which provide that the employer shall be liable only for the disability resulting from an injury to an employee incurred during his/her current employment without regard to a preexisting handicap. Where reference is made to workers' compensation coverage, it also includes second injury coverage where such liability is incurred by the provider.

The following illustrates alternatives to full insurance coverage from commercial sources which providers, acting individually or as part of a group or a pool, can adopt to obtain malpractice, and comprehensive general liability, unemployment compensation, workers' compensation, and employee health care insurance protection:

1. Insurance purchased from a commercial insurance company which provides coverage after a deductible or coinsurance provision has been met;

2. Insurance purchased from a limited purpose insurance company (captive);

3. Total self-insurance; or

4. A combination of purchased insurance and self-insurance.

The conditions for Medicare reimbursement stated below are for provider malpractice liability and comprehensive general liability coverage in conjunction with malpractice coverage or for malpractice liability coverage only, unemployment compensation, workers' compensation insurance, and employee health care insurance, not for liability coverage costs such as automobile liability, fire, theft, or general liability only.

B. Effect on Interns, Residents, and Other Provider-Based Physicians.--The cost of malpractice coverage that a provider incurs for its employee interns and residents is allowable, subject to the provisions of §2120. However, the cost of malpractice coverage incurred by a provider for the personal risks of physicians other than interns and residents for direct medical care rendered to patients is not allowable except where the provider incurs such cost for its hospital-based physicians as described in Regulations No. 5, §405.480(f) and §2108ff of this manual. This cost incurred by the provider for its hospital-based physicians must be considered part of the physicians' total compensation. Regulations No. 5, §405.484, requires that this total physicians' compensation must be apportioned between the services rendered to the institution (Part A) and the services rendered to patients (Part B). The portion of the physicians' compensation for services rendered to the institution is an allowable provider cost. The portion of the physicians' compensation for services rendered to patients is reimbursed under the supplementary medical insurance program through the appropriate billing or cost-apportionment mechanism.

C. Documentation Required Where Type of Insurance Changes.--A provider usually selects the type of arrangement which is most reasonable and prudent, taking into account all pertinent facts and circumstances related to its organization and operation. When a change is made from commercial insurance as described in §2161 to one of the alternatives or from one alternative to another, the provider must document a comparative analysis which shows that the provider's choice results in a reasonable cost for the coverage offered and that the extent of coverage is consistent with sound management practices. The provider's comparative analysis should be performed on a periodic basis, usually every 3 to 5 years, to assure consistent application of the prudent buyer principle and to properly monitor the cost effectiveness of the insuring method being applied. The provider should retain these analyses to assist its intermediary in determining the reasonableness of the insurance costs. These analyses should show the following information:

o The administrative cost for the arrangements, including the cost for the maintenance of a fund by a fiduciary, legal cost, cost of a risk management program, cost of claims management program, actuarial costs, and other related costs.

o The necessary contributions to the fund based on an actuarial determination (as described in §2162.7C) of anticipated losses for malpractice, comprehensive general liability coverage in conjunction with malpractice, unemployment compensation, workers' compensation, and employee health care insurance. The determination of necessary contributions to the fund may also be made by a governmental agency for unemployment compensation and workers' compensation.

o The cost of any insurance to supplement self-insurance, like stop-loss insurance.

o The comparative commercial insurance premium.

2162.1 Insurance with a Deductible or Coinsurance Provision.--If you purchase an insurance policy with a deductible or coinsurance provision from a commercial insurance company, the cost of the insurance coverage for losses in excess of the deductible or coinsurance is an allowable cost, to the extent that the amount of coverage is consistent with sound management practices. (See §2162.5 for the discussion of losses related to deductibles or coinsurance.)

2162.2 Insurance Purchased From a Limited Purpose Insurance Company.--

A. Premium Costs.--Some providers, groups of providers, and State hospital associations have established limited purpose insurance companies (often known as captive insurance companies) to insure themselves against malpractice and, in some instances, comprehensive general liability losses as well as unemployment and workers' compensation insurance and employee health care costs. The regular premiums (other than the supplemental premiums) paid to such companies for provider malpractice and comprehensive general liability coverage in conjunction with malpractice coverage, or for malpractice liability coverage only, as well as unemployment insurance costs paid to the Federal Government and to the States, workers' compensation insurance costs paid to commercial insurance companies, and employee health benefit premiums paid to such companies are allowable costs if they are not in excess of the cost of available comparable commercial insurance premiums and meet the reasonable cost provisions of §2100. If comparable insurance premiums are not available, the captive insurance company must obtain an evaluation of the adequacy and reasonableness of its insurance premium by an independent actuary, commercial insurance company, or broker as described in §2162.7 C. The allowable premium may not exceed the amount which such evaluation determines to be reasonable.

In addition, supplemental premiums which are assessed by limited purpose insurers to build reserves against contemplated losses, as distinguished from capital costs, are allowable costs if, when added to the regular premium, the total premium costs do not exceed a commercial insurance premium for comparable coverage. The supplemental premiums must have the essential characteristics of normal insurance premiums, i.e., they must stand at risk against potential losses and must be available to support losses. Any excess premiums are allowed in a subsequent cost reporting period to the extent that, when added to premiums paid to the captive insurance company in that period for comparable coverage, the total premium costs do not exceed the comparable commercial insurance premiums for that period. Premiums paid to a limited purpose insurance company are recognized in your allowable costs only if all of the conditions of this section are met.

Any funds returned to the insured by the insurer (rebates, distributions, etc.) must be offset against the costs in the year you receive them. Such returned funds must be offset against the costs of the Employee Health and Welfare Cost Center for employee health care and against the costs of the Administrative and General Cost Center for other than employee health care. However, if a captive insurance company is liquidated, no offset is required for the return of capitalization costs previously paid by providers receiving the rebate. If payments are made to other than providers, e.g., the home office of a chain organization, appropriate adjustment of your cost is still necessary. Proper allocation of distributions by the home office to you must be made based on the appropriate facts in each situation.

The premium paid by you for hospital-based physicians is subject to the requirements in §2162 B.

The captive insurance company must have an adequate claims management and risk management program and, in cases where the captive insurance company is designed to cover employee health care insurance, it is suggested that a coordination of benefits program be employed as described in §2162.7 D. In cases where a limited purpose insurance company has both Medicare and non-Medicare participating providers paying premiums, such premiums must be determined so that Medicare providers do not share in premium costs that must be borne by the non-Medicare providers, and non-Medicare providers do not share in premium costs that must be borne by Medicare providers.

If a provider or group of providers is related to the insurer through ownership or control, as defined in Chapter 10, the following additional provisions apply:

1. The captive insurance company must be established in and meet the appropriate insurance laws of one of the United States, District of Columbia, or foreign government, if it is formed offshore.

2. The excess of actuarially determined loss reserves and related operating expenses over actual losses and related operating expenses and gains and losses from investments must be taken into account in establishing reasonable premium levels which do not reflect a profit factor.

3. If you terminate from the Medicare program, you must obtain a final determination of the adequacy of premium reserves as of the date of termination. This determination must be obtained from an independent actuary, commercial insurance company or broker as described in §2162.7. Any reserves that are deemed excessive at the date of termination must be offset against your allowable costs in your final cost report. If reserves are deemed inadequate, additional premium payments subsequent to the date of termination are not allowable provider costs.

4. In the case of offshore captives, investments by a related captive insurance company are limited to low risk investments in United States dollars such as bonds and notes issued by the United States Government; debt securities issued by United States corporations or governmental entities within the United States rated in the top two classifications by United States recognized securities rating organizations at the time of investment; debt securities of foreign subsidiaries of United States corporations rated in the top two classifications by United States recognized securities rating organizations at the time of investment where the parent United States corporations guaranteed (on the face of the securities) payment of the subsidiaries' securities; and deposits (including Certificates of Deposit) in United States banks or their foreign subsidiaries, and foreign banks rated in the top two short term classifications by United States recognized securities rating organizations. Low risk investments may also include investments of non-United States issuers including foreign governments and corporations and supranational agencies rated in the top two classifications by United States recognized securities rating organizations (effective with investments made on or after 10/11/91). Effective for investments made on or after 10/06/95, the limitation on related offshore captive insurance company investments is extended to include the above described low risk investments rated in the top three classifications by United States recognized securities rating organizations. Additionally, investments may include dividend paying equity securities listed on a United States stock exchange provided that the investment in equity securities does not exceed 10 percent of the company's admitted assets, with the investment in any specific equity issue further limited to 10 percent of the total equity security investment. (All such captives are required to annually submit to a designated intermediary a certified statement from an independent certified public accountant or actuary attesting to compliance or non-compliance with these requirements for the previous period.) These investments cannot be pledged or used as collateral for loans obtained by the captive or parties related to the captive either directly or indirectly, nor may investments be made in a related organization.

Recognizing that a captive's portfolio may presently contain other than low risk United States based investments and that possible losses in converting a captive's current portfolio to acceptable investments may result, the Medicare program allows any investments owned by the captive on July 31, 1978 to be considered acceptable investments under this section. As investments held by the captive on July 31, 1978 subsequently mature, are exchanged for other types of investments or sold, any proceeds that are reinvested must be invested in accordance with the provisions of this section.

5. Loans or any transfer of funds by the insurance company to policy holders, owners of providers, or parties related to them are prohibited.

B. Capitalization Costs.--The initial or any subsequent capital payments, as distinguished from supplemental premiums as described in subsection A, made by you to establish or maintain limited purpose (captive) insurance companies, including companies established by State hospital associations or others, are not allowable under Medicare. Such payments include the purchase of stock or surplus certificates (mutual insurance company), or other payments to establish capitalization levels such as special dues assessments paid by you to a hospital association which then establishes a captive insurance company.

2162.3 Self-Insurance.--You may believe that it is more prudent to maintain a total self-insurance program (i.e., the assumption by you of the risk of loss) independently or as part of a group or pool rather than to obtain protection through purchased insurance coverage. If such a program meets the conditions specified in §2162.7, payments into such funds are allowable costs.

2162.4 Combination of Purchased Insurance and Self-Insurance.--You may believe it appropriate to self insure some of the risk independently or as part of a group or pool and purchase insurance for the remainder of the risk. Where you decide to fund all or some of the risk covered through self-insurance, payments into a fiduciary fund are allowable costs if you or the pool sets up a program which meets the conditions specified in §2162.7. The cost of the insurance is also an allowable cost subject to the conditions of §2161.

2162.5 Allowability of Actual Losses Related to Deductibles or Coinsurance.--Where you, at your option, are willing to commit your resources toward meeting first dollar losses through a deductible (as defined below), losses relating to the deductible are allowable costs in the year paid without funding if the aggregate deductible is no more than the greater of 10 percent of your (or, if appropriate, a chain organization's) net worth--fund balances as defined for Medicare cost reporting purposes--at the beginning of the insurance period or $100,000 per provider. The same rule applies where you coinsure with an insurance carrier. This requirement is deemed a reasonable test as to whether you are acting prudently in this regard. So long as you stay within the above limitations, you can be assumed to be exercising sound judgment in deciding to meet first dollar losses or coinsurance payments out of available resources. This requirement also permits you to pay reasonable losses without incurring costs to fund such payments. If your deductible or coinsurance exceeds the above requirements and the provider does not make payments into a fiduciary fund as required by §2162.7, any losses paid by the provider in excess of the greater of 10 percent of the provider's or, if applicable, a chain organization's net worth, or $100,000 per provider, are not allowable.

For purposes of this section, a "deductible" refers to the amount of first dollar losses not covered by a purchased insurance policy, a funded self-insurance program, or a combination of both.

2162.6 Losses in Excess of Coverage.--Where a provider incurs losses which are in excess of purchased commercial and/or limited purpose insurance coverage or actuarially determined funded contributions to an approved self-insurance fund in meeting specified deductibles, coinsurance provisions, or total self-insurance, such costs are allowable in the year paid where the provider submits evidence to the satisfaction of the intermediary that the insurance coverage or funding levels reflected the decisions of prudent management.

Losses in excess of coverage for events that occurred prior to the provider's participation in the Medicare program, where the actual amount of the loss was unknown and could not be determined at the time of the event, are allowable, provided the determination and actual payment of the losses are made subsequent to the provider's entry into the program, and assuming that the required evidence of prudent management in establishing insurance coverage or funding levels has been submitted.

2162.7 Conditions Applicable to Self-Insurance.--

A. Definition of Self-Insurance.--Self-insurance is a means whereby a provider(s), whether proprietary or nonproprietary, undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities.

If a provider enters into an agreement with an unrelated party that does not provide for the shifting of risk to the unrelated party, such an agreement shall be considered self-insurance. For example, any agreement designed to provide administrative services only shall be considered self-insurance and must meet the requirements specified below. If administrative services agreements do not meet these requirements, any amounts funded as part of the agreement will not be allowed. Payments from the fund, however, will be treated on a claim-paid basis as specified in §2162.3.

There may be situations in which there is a fine line between self-insurance and purchased or commercial insurance. This is particularly true of "cost-plus" type arrangements. As long as there is at least some shifting of risk to the unrelated party, even if limited to situations such as provider bankruptcy or employee termination, the arrangement will not be considered self-insurance.

B. Self-Insurance Fund.--The provider or pool establishes a fund with a recognized independent fiduciary such as a bank, a trust company, or a private benefit administrator. In the case of a State or local governmental provider or pool, the State in which the provider or pool is located may act as a fiduciary. The provider or pool and fiduciary must enter into a written agreement which includes all of the following elements:

1. General Legal Responsibility.--The fiduciary agreement must include the appropriate legal responsibilities and obligations required by State laws.

2. Control of Fund.--The fiduciary must have legal title to the fund and be responsible for proper administration and control. The fiduciary cannot be related to the provider either through ownership or control as defined in Chapter 10, except where a State acts as a fiduciary for a State or local governmental provider or pool. Thus, the home office of a chain organization or a religious order of which the provider is an affiliate cannot be the fiduciary. In addition, investments which may be made by the fiduciary from the fund are limited to those approved under State law governing the use of such fund; notwithstanding this, loans by the fiduciary from the fund to the provider or persons related to the provider are not permitted. Where the State acts as fiduciary for itself or local governments, the fund cannot make loans to the State or local governments.

3. Payments by Fiduciary.--The agreement must provide that withdrawals must be for malpractice and comprehensive general liability or unemployment or workers' compensation insurance losses, or employee health benefits coverage only and those expenses listed in §2162.8. Any rebates, dividends, etc., to the provider from the fund will be used to reduce allowable cost. Furthermore, evidence of a practice of payments from the fund for purposes unrelated to the proper administration of the fund may result in a withdrawal of recognition of the self-insurance fund by the Medicare program. In such instances, payments into the fund will not be considered an allowable cost. Intermediaries will submit incidents of impropriety to the appropriate regional office.

4. Termination.--The agreement must state that upon termination from the Medicare program, the provider must obtain a determination of the adequacy of the fund balance as of the date of termination from an independent actuary, insurance company, or broker (as defined in B below). Any reserves that are deemed excessive must be offset against the provider's allowable costs in the provider's final cost report. If the reserve fund is deemed inadequate, additional contributions to the fund subsequent to the date of termination are not allowable.

5. Reporting.--The agreement must require that a financial statement be forwarded to the provider or pool members by the fiduciary no later than 60 days after the end of each annual insurance reporting period. This statement must

show the balance in the fund at the beginning of the period, current period contributions, and amount and nature of final payments, including a separate accounting for claims management, legal expenses, claims paid, etc., and the fund balance. This report and fiduciary's records must be available for intermediary review and audit.

6. Income Earned.--The agreement must provide that any income earned by the fund must become part of the fund and used in establishing adequate fund levels.

C. Soundness of the Fund.--The provider submits to the intermediary an annual certified statement from an independent actuary, insurance company, or broker that has actuarial personnel experienced in the appropriate field of medical malpractice and general liability insurance, unemployment compensation, workers' compensation or employee health care insurance. To be independent, there must not be any financial ownership or control, as defined in Chapter 10, either directly or indirectly in the provider.

The actuary, insurance company, or broker shall determine the amount necessary to be paid into the fund. The fund should include reserves for losses based on accepted actuarial techniques customarily employed by the section of the insurance industry writing the type of insurance coverage the fund is designed to provide, and expenses related to the self-insurance fund as specified in §2162.8. The actuary, insurance company, or broker shall also provide for an estimate of the amounts in the fund that are in excess of what is reasonably needed to support anticipated disbursements from the fund. This excess amount must be treated as specified in §2162.10. Where funds have been established to cover employee health care, the actuary, insurance company or broker must limit fund payments to the cost of insurance premiums for comparable purchased coverage at the same level offered by the fund. Fund payments exceeding this amount will be treated as excess payments.

The actuary, insurance company, or broker must state the actuarial basis and the coverage period used in establishing reserve levels. Reserves will not be recognized as allowable Medicare costs for losses specifically denied by other subsections of §§2160, 2161, and 2162. Thus, reserve payments will not be recognized for items such as:

1. Losses in excess of the greater of 10 percent of a provider's net worth or $100,000 where a provider elects to pay losses directly in lieu of establishing a funded self-insurance fund (§2162.5);

2. Losses in excess of coverage levels which an intermediary deems do not reflect the decisions of prudent management (§2162.6).

The actuary, insurance company, or broker must provide its workpapers to Medicare intermediaries upon request.

There must be separate accountability to reflect all operations within each fund.

D. Claims Management, Risk Management, and Coordination of Benefits Program. -A provider or pool has an ongoing claims process and risk management program. The provider or pool must demonstrate to the intermediary that it has an ongoing claims process to determine whether malpractice and comprehensive general liability, unemployment and workers' compensation insurance liabilities, and the liability for employee health care insurance exist, their causes where applicable, and the cost of claims. A provider or pool may either utilize its qualified personnel or an independent contractor, such as an insurance company, to adjust claims. In addition, a provider or pool must obtain adequate legal assistance in carrying out its claims process. Each provider must also have an adequate risk management program to examine the cause of losses and to take action to reduce the frequency and severity of them. Such risk management program has the essential characteristics of programs required by insurers which currently insure providers for these risks. Therefore, a provider must have an ongoing safety program, professional and employee training programs, etc., to minimize the frequency and severity of malpractice and comprehensive general liability, as well as workers' compensation insurance incidents.

For funds established to cover employee health care, the provider, or its fiduciary, should consider the institution of an effective coordination of benefits program. A program of this nature would seek to determine whether any beneficiary of the fund is partly or fully covered by another insurance plan, such as a family plan provided to a spouse as a fringe benefit of employment or a private insurance plan held by the beneficiary with a commercial insurance company. A program of this type would assure that each health plan pays its appropriate share of the expenses related to the beneficiary's illness, thus reducing the liability for full payment by the provider's fund.

E. Trust Mechanism Applicable to Employee Health Care.--If the provider wishes, the program will recognize the establishment of self-insurance funds for employee health care in accordance with the provisions of §501(c)(9) of the Internal Revenue Code. This code section grants a tax free exemption to funds established in trust, provided the funds are used to pay for life, sick, accident or other employee benefits.

Application of this Internal Revenue procedure would allow a provider to establish its employee health care self-insurance fund without relinquishing legal title to the fund to an independent fiduciary. In addition, fund trustees may also be employees of the provider, as long as the employees act independently in their administration of the trust. All other conditions applicable to self-insurance elicited in this manual section, however, will be applicable to employee health care trusts established under this Internal Revenue procedure, i.e., payments by fiduciary, termination, reporting, soundness of the fund, etc.

2162.8 Expenses Related to Losses Paid Out of Self-Insurance Fund.--The following expenses will be considered costs attributable to a self-insurance fund established by a provider or pool: expenses of establishing the provider fund or pool, expenses for administering the claims management program, expenses involved with maintenance of the fund by the fiduciary, legal expenses, actuarial expenses, excess insurance coverage (if purchased by the fiduciary or pool), risk management (if performed by the fiduciary or

pool), and a coordination of benefits program (if performed by the fiduciary pool or provider) to the extent that such expenses are related to the provider's self-insurance program. All other expenses will not be considered costs attributable to the fund, but should be included in provider administrative and general costs in the year incurred.

2162.9 Reimbursement Principles Where a Provider Has Self-Insurance.--

A. Medicare's participation in the fund contributions will be limited to actual funded payments made by a provider into the fund and only to the extent of the amounts permitted by §2162.7C. Accruals of payments to be made into the fund are allowable costs in the year of accrual if paid within 75 days after the end of a provider's cost reporting period. Payments made after the 75th day will be deemed allowable in the reporting period paid, provided the total contributions made in that period do not exceed the amount prescribed by the actuary as necessary for the adequacy of the fund.

B. Total fund contributions for employee health care are included in the Employee Health and Welfare Cost Center and for other than employee health care in the Administrative and General Cost Center and allocated in the cost-finding process in the same manner as commercial insurance premium costs.

C. Medicare's share of allowable contributions to a fund which meets the conditions in §2162.7 will be included in the calculation of the regular interim reimbursement. The interim rate will be based on the payments required by the actuary, insurance company, or broker for the current year under the agreement setting up the fund.

D. Interim reimbursement for actual losses related to deductibles or coinsurance which are not covered by a funded self-insurance program as described in §2162.5 will be based on the provider's estimate of Medicare's share of total paid claims to be made the coming year. Factors such as the provider's previous years' claims paid experience, claims pending, etc., should be used in establishing the estimated losses for interim payment purposes.

2162.10 Treatment of Excess Reserves.--Contributions or pool payments for any period in excess of the amount required by §2162.7C as needed to support disbursement are not allowable costs for such period but may be allowed in the subsequent reporting period to the extent that, when added to contributions paid in the subsequent year, the sum does not exceed the prescribed amount.

2162.11 Effective Date and Retroactive Application.--

A. Malpractice and Comprehensive General Liability.--The provisions of this section are effective with payments for malpractice and comprehensive general liability protection in conjunction with malpractice protection or malpractice liability protection only, beginning April 1, 1977. If a provider did not have full coverage under commercial insurance after December 31, 1974, and disbursed funds for such protection under alternative arrangements, such costs of protection are allowable when:

1. The disbursement was made after December 31, 1974;

2. The intermediary determines that the arrangement and cost for securing such protection were reasonable; and

3. The provider conforms to the provisions of this section before:

a. November 1, 1977, for arrangements other than through purchase of protection from a captive insurance company; or

b. July 1, 1978, for protection purchased from a captive insurance company.

Where a provider or group of providers included self-insured losses and related expenses in allowable costs after December 31, 1974, and before April 1, 1977, in accordance with §2161.B, such providers may request reopening and revision of cost reports for applicable cost reporting periods to recognize reasonable disbursements for such protection in lieu of the costs previously allowed, if the self-insurance arrangement met the provisions of this section before November 1, 1977. Such reopening and revision are not mandatory for periods prior to April 1, 1977.

If a provider has made payments to a self-insurance fund or a pool during the period after December 31, 1974, and before April 1, 1977, an independent actuary, insurance company, or broker must review the adequacy of the payments made by the end of the cost reporting period ending on or after November 1, 1977. If the actuary, insurance company, or broker believes that the payments made are excessive, then reimbursement will be limited to the amount determined necessary by the actuary, insurance company, or broker. Any excess amounts may be carried forward and included in the subsequent year's contribution to the extent that, when added to contributions paid in the subsequent year, they do not exceed the amount determined necessary by the actuary, insurance company, or broker.

In a self-insurance or pool arrangement, contributions must be paid into the fund within 75 days after the end of a cost reporting period for the contributions to be recognized as an allowable cost for that cost reporting period. Any withdrawals from the fund for other than malpractice losses or comprehensive general liability losses in conjunction with

malpractice coverage and related expenses must be offset against allowable contributions to the fund. In addition, all income earned by the fund must become part of the fund and used to establish adequate fund levels. Any income earned and used for other than this purpose must be offset against allowable payments in the year earned.

B. Unemployment and Workers' Compensation Insurance Coupled with Second Injury Coverage.--The provisions of this section are effective with payments for unemployment and workers' compensation coupled with second injury coverage beginning January 1, 1979. If a provider did not have full coverage under commercial insurance for any cost report that can be reopened in accordance with 42 CFR 405.1885 and disbursed funds for such protection under alternative arrangements, such costs of protection are allowable when:

1. the disbursement applies to January 1, 1976, or later; and

2. the provider conforms to the provisions of this section before January 1, 1980.

Where a provider or group of providers included self-insured losses and related expenses in allowable costs in accordance with §§2161.B or 2122.5C for open years, such providers may request reopening and revision of cost reports for applicable cost reporting periods to recognize reasonable disbursements for such protection in lieu of the costs previously allowed if the self-insurance arrangement meets the provisions of this section before January 1, 1980. Such reopening and revisions are not mandatory.

Where a provider has made payments to a self-insurance fund or a pool during the period after December 31, 1975, and before January 1, 1979, an independent actuary, insurance company or broker must review the adequacy of the payments made by the end of the first cost reporting period ending on or after June 30, 1979. If the actuary, insurance company or broker believes that the payments made are excessive, then reimbursement will be limited to the amount determined necessary by the actuary, insurance company, or broker. Any excess amounts may be carried forward and included in the subsequent year's contribution to the extent that, when added to contributions paid in the subsequent year, they do not exceed the amount determined necessary by the actuary, insurance company or broker.

In a self-insurance or pool arrangement, contributions must be paid into the fund within 75 days after the end of the cost reporting period for the contributions to be recognized as an allowable cost for that cost reporting period. Any withdrawals from the fund for other than unemployment or workers' compensation premiums or claims and related expenses must be offset against allowable contributions to the fund. In addition, all income earned by the fund must become part of the fund and used to establish adequate fund levels. Any income earned and used for other than this purpose must be offset against allowable payments in the year earned.

C. Employee Health Care Insurance.--The provisions of this section related to insurance purchased from a limited purpose insurance company (captive), total self-insurance or a combination of purchased insurance and self-insurance are effective with cost reports settled on or after January 15, 1983, and cost reports under appeal as of or subsequent to January 15, 1983. Prior to this date, payments made to a captive insurance company or to a self-insurance fund designed to provide employee health care coverage shall not be considered an allowable cost at the time the payment was made. Cost recognition for periods prior to the effective date shall be limited to the premium cost of commercial insurance purchased to provide this coverage or to the actual cost of the health expenses paid on behalf of the employee at the time such expenses were actually incurred.

2162.12 Buy-Out Cost to Convert from a State-Administered Fund to a Self-Insurance Fund for Unemployment Compensation or Workers' Compensation Insurance.--The charge made by a governmental agency for the cost of pending and expected claims of employees of a business entity which discontinues purchasing insurance coverage from the governmental agency is considered a buy-out cost. Where a provider or group of providers or chain of providers incurs a liability representing a "buy-out" cost to enable those providers to set up their own self-insurance fund for unemployment compensation or workers' compensation coverage, the liability is an allowable cost of the year incurred to be proportionately spread among the providers which are part of the buy-out arrangement in an amount directly related to the provider's claims to be assumed by the State. Where the State permits payment over a period greater than 1 year and issues an annual assessment of the amount due, then the amount to be included in allowable costs cannot exceed the assessment. This assessment establishes the annual liability which the provider must pay to the State. See §2305 where the amount is accrued on the books.

2162.13 Absence of Coverage.--Where a provider, other than a governmental (Federal, State, or local) provider, has no insurance protection against malpractice or comprehensive general liability in conjunction with malpractice, either in the form of a limited purpose or commercial insurance policy or a self-insurance fund as described in §2162.7, any losses and related expenses incurred are not allowable.

2162.14 Governmental Providers.--For all governmental providers (Federal, State, or local), Medicare will reimburse its proportionate share of actual losses in the year paid, without funding or subject to the deductible provisions of §2162.5, but only if the provider demonstrates to its intermediary that it has a claims management and risk management program as described in §2162.7D.